STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155636	B. WIN	G		01/15/	2013
	OVIDER OR SUPPLIER	₹		1924 W	ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Complaint INO resulted in a paragraph of the complaint INO Substantiated. deficiencies reare cited at F2 Survey dates:	Federal/state lated to the allegations 79 and F323.  January 9, 10, 2013 ey dates: January 11, 2013 r 000241 er 155636 00291310  son RN pe:	F00	00	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credit Allegation of Compliance.	ot s n of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000241

PRINTED: 02/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155636		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/15/2013	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD	
HARRIS	ON TERRACE			APOLIS, IN 46219	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	These deficier findings cited i			CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	.IE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155636	B. WING			01/15/	2013
	ROVIDER OR SUPPLIER			1924 W	DDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID PREFIX TAG F0279 SS=D	SUMMARY S' (EACH DEFICIEN REGULATORY OR  483.20(d), 483.20 DEVELOP COMP PLANS A facility must use assessment to de the resident's con  The facility must care plan for each measurable object meet a resident's mental and psychidentified in the control of the care plan must hat are to be furnithe resident's high mental, and psychians and psychians are to part of the care plan must have a plan must	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  PREHENSIVE CARE  The the results of the evelop, review and revise exprehensive plan of care.  The develop a comprehensive exprehensive plan of care.  The develop a comprehensive exprehensive and timetables to exprehensive and timetables to exprehensive assessment.  The develop a comprehensive exprehensive and timetables to exprehensive assessment.  The develop a comprehensive exprehensive and timetables to exprehensive assessment.  The develop a comprehensive exprehensive assessment.	F			Ē	(X5) COMPLETION DATE
	that would otherw §483.25 but are resident's exercisincluding the right §483.10(b)(4). Based on recollinterview, the far resident's saft needs were mecomprehensive manner for a rewith sexually in and verbally agwandering behaltermined to ustaffing for the and other resident.	rise be required under not provided due to the e of rights under §483.10, at to refuse treatment under actility failed to ensure tety and psychosocial et by not developing e care plans in a timely esident (Resident E) appropriate, physically agressive, and intrusive aviors and who was require one on one safety of the resident	F027	79	F279  A comprehensive care plan habeen developed for the resider affected by the alleged deficier practice.  Residents who exhibit new or worsening behaviors have the potential to be affected by the alleged deficient practice. All other residents with sexually inappropriate, physically and verbally aggressive, and intrus wandering behaviors, care plan were reviewed to ensure residents had a comprehensive care plan to address the	nt nt ive ns	02/08/2013

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DDIG	00	COMPL	ETED	
		155636		LDING	<u> </u>	01/15/	2013	
			B. WIN	_	ADDRESS STATE STREET	<u> </u>	-	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
LIABBIO					VELLESLEY BLVD			
HARRIS	ON TERRACE			INDIAN	IAPOLIS, IN 46219			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Findings include	de:			behaviors. An inservice on			
	-				Behavior Management includ	•		
	1. The record	of Resident E was			sexually inappropriate behavior			
		1/10/13 at 3:00 p.m.			was provided to staff by the S	тап		
	.51.51.54 511 6				Development Coordinator on 1/11-13/2013.			
	Diagnosas ins	luded but were set			1/11-13/2013.			
	1	luded, but were not			Staff will call the DNS when a	nv		
	· ·	n's syndrome,			physically aggressive, verbally	•		
		tro esophageal reflux			aggressive or sexually	,		
	disease, hypei	rlipidemia, and celiac			inappropriate behaviors occur	-		
	disease.				that is directed to another			
					resident. An immediate			
	An admission	Minimum Data Set			intervention will be put into pla			
		ssment dated 12/18/12			at that time. Nurses will condu			
	, ,	dent E was significantly			shift to shift report on any new	V		
		•			behavior management			
		paired, was unable to			interventions – relaying the interventions to licensed and			
		iterview to assess his			unlicensed staff. CNA assignr	ment		
		behaviors, ambulated			sheets are updated during ID			
	with assistance	e, and required staff			meeting. During weekends the			
	assistance for	activities of daily living.			weekend supervisor will upda			
					CNA assignment sheets. The	)		
	Documentation	n indicated Resident E			IDT will review interventions to			
		to the facility on			evaluate the effectiveness and			
	12/11/12.	o the facility off			ensure there is no reoccurren	ce.		
	14/11/14.				The behavior monitoring flow			
		( B : 1 / E			sheet will be completed every			
	_	s for Resident E			shift, and reviewed by the unimanagers to ensure care plan			
	indicated:				interventions were implement			
					New and worsening behaviors			
	12/20/12 5:46	A.M.: "The resident			be reviewed by the IDT on the			
	was observed	kissing another female			next business day. Intervention			
		the mouth and it was			will be identified. The care pla			
	·	al. The resident was			and care sheets will be update	ed		
					at that time.			
		inappropriately (sic)						
	I ~	esident. The resident			To ensure compliance, the	_		
		ely removed and told			DNS/Designee is responsible			
	the behavior w	as unacceptable. The			the completion of the Behavio	r		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00	COMPLETED
155636 A. BUILDING	01/15/2013
B. WING	_
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZII	r CODE
1924 WELLESLEY BLVD	
HARRISON TERRACE INDIANAPOLIS, IN 46219	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C	CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
resident became verbally aggressive Management CQI to	ol weekly
and stated, 'Make me stop you old times 4 weeks, bi-mo	onthly times 2
months and then qua	
Continued compliance	I
maintained for 2 con	
12/20/12 6:45 P.M.: "Group of Xmas quarters. The results	
(Christmas) caroler's (sic) here on audits will be reviewed committee overseen	
unit singing Amas cards (sic). Res	, I
(resident) attempted to walk up to	
visitor with lips puckered for a kiss.  to ensure compliance	•
This writer immediately got between	
res et (and) visitor et removed res	
away from visitor. Other res started	
yelling (symbol for "at") this res to sit	
down and be quiet"	
12/20/12 9:37 P.M.: "Res cont	
(continued) to have behaviors this	
shift, res walked up to a female res et	
exposed his (sic) self by holding his	
penis in his hand et laughing (symbol	
for "at") resWhen this writer	
assisted res to bed started (sic) trying	
` ' ' "	
to kiss this writer. This writer	
immediately explained to res that he	
should not kiss anyone, or expose	
himself to anyone. Res stated 'make	
me. Res put on 15 min (minute) chk's	
(checks) for behaviors."	
12/21/12 10:02 A.M."IDT	
(Interdisciplinary Team) met to	
discuss residents (sic) new and or	
worsening behavior that occurred on	
12/19/12, 12/20/12, and 12/21/12.	
Throughout these days resident was	

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155636	. BUILDING	00	COMPLETED 01/15/2013
NAME OF PROVIDER OR SUPPLIER  HARRISON TERRACE	1924 WELL	RESS, CITY, STATE, ZIP CODE LESLEY BLVD OLIS, IN 46219	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
noted to have been intrusively wandering in and out of other residents (sic) rooms, throwing his meal beverages on the floor as well as eat (sic) others (sic) foods, exposing himself to other residents, becoming verbally and physically aggressive toward staff, attempting to kiss and touch visitors that came on to the unit and kissing resident (number of resident) without her consentStaff interventions were unsuccessful. Resident continued to exhibit behaviors until he was assisted to bed"  12/23/12 1:56 A.M.:"returned to this unit (Mapleton) early evening, Bx. (behaviors) began almost immed., (immediately) ambulated to other resident rooms and entered, residents began to yell"  12/26/12 10:55 A.M.: "Res wandered into room (a room on the Chatham Arch unit) and res (Resident F) redirected this res out to hallway. When this res attempted to go back into rm (room) res (Resident F) made contact with this res left side of faceStarted 15 minute checks for safety."  Resident E's record contained no documentation of 15 minute checks.			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155636	B. WIN			01/15/	2013
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	· ·		1924 W	ELLESLEY BLVD		
HARRISO	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t 10:30 A.M. the					
		ctor indicated he had					
	no documentation of 15 minute						
	checks being p	performed.					
	12/27/12 7·01	P.M.:"res has been					
		idering into res rooms					
	1	tinuously this shift, res					
		gs from peers and worn					
	1	pecomes agitated when					
		to redirect him and					
	'	s (sic) belongings,					
	yelling and cur	. ,					
	yening and car	311g					
	12/28/12 5:19	P.M.: "Transferred to					
		ham unit) res continues					
	,	nd out of peers (sic)					
		their belongings,					
	l – – – – – – – – – – – – – – – – – – –	aff when redirected"					
		an whom roun ootou					
		A.M.: "Resident cont					
	l	wander in and out of					
		s (sic) rooms and take					
		s. Staff redirects					
	resident but thi	is causes an increase					
	in agitation on	residents (sic) part. At					
	10:15 a.m., res	sident was walking in					
	hall by nurses	station. A female					
	resident walkin	ng in the other direction					
		nt of res and reached					
	out to touch hir	m on his arm. Res then					
	raised his fist a	and made contact with					
		female resident. Staff					
		eparated the two. The					
	· · · · · · · · · · · · · · · · · · ·	een placed on constant					
	l	1	L				1

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155636	B. WIN	G		01/15/	2013
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ELLESLEY BLVD		
HARRIS	ON TERRACE			INDIAN.	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	•	on). Family has been					
		ttempting to arrange					
	someone to come in and sit with him						
	awhile to calm	him down."					
		ecord contained no					
	documentation						
		n 1/13/13 at 10:30					
		utive Director indicated					
	he had no doci	umentation of constant					
	observation be	ing performed.					
		.M.: "res has been					
	_	nd out of res rooms					
	_	ongings, putting their					
	clothes on, tak	ing clothes out of					
	drawers throwi	ng them all over the					
	room, yelling a	nd taking things off the					
	linen cart stuffi	ng them in his pants"					
		.M.: "res acting very					
		luring breakfast res					
		g other residents,					
	_	staff for a kiss, putting					
	•	he air as if he wants to					
		andering in and out of					
	other res room	_					
		d putting others clothes					
	_	fficult to redirect					
	-	Is and screams when					
	redirected caus	sing a big scene"					
	1/03/13 2:32 A						
		g clothes out of					
	roommates (si	c) drawers and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155636	B. WIN	IG		01/15/	2013
NAME OF P	PROVIDER OR SUPPLIEF	<b>.</b>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ELLESLEY BLVD		
HARRIS	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	chesthe beca	•					
aggressive using profanityalso							
	continues to pull penis out and show it to staff"						
	าเ เอ รเลท						
	1/04/13 8:30 A.M.: "Resident						
		iss a female resident					
	•	Res was redirected to					
		when writer left his side					
	_	nutes to obtain meds					
	(medications) f						
	,	female resident from					
		lled out his penis. He					
	•	try to rub it on female					
	residents (sic)	•					
	, ,						
	1/05/13 11:14	A.M.: "stood behind					
	hospice aide a	nd pantomimed sexual					
	jestures (sic) w	vith his hips while					
	patting his gen	italsthen unfastening					
	his pants"						
		.M.: "Resident cont					
	,	h hoarding behaviors in					
		ts to redirect. At					
	· ·	dent mocked another					
		eating everything the					
	_	ng to staff. When					
	• •	Res responded by					
	, ,	omma is ugly' and					
		Idle fingers first at res					
		he two had to be					
		n the other became					
		ng at res without					
	making contac	t. In addition, res					

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	of Correction identification number:  155636	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 01/15/2013
	PROVIDER OR SUPPLIER  ON TERRACE	1924 W	ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	swung a belt at an aides (sic) head today. When cat in the hole was failing to get staff attention, res began yelling py and laughing."  1/07/13 11:05 A.M.: "Res noted by this writer to have another residents (sic) stereo headphones tucked down the front of his pants. Approached res and stated that I need to see those so they did not get broken. Res immediately began yelling 'No, they are mine" and took the headphones out and held them behind his back. When writer reached for headphones, res swung fist and attempted to make contact with staff members (sic) faceRes escorted from the female residents (sic) room where this occurred"  1/08/13 3:02 P.M.: "Res was wandering in and out of other res rooms this shift taking their belongings, trying to box with the staff when redirected, when asked to not do certain things res states, 'who's gonna make me?' and res was also caught trying to hump one of the female residents in the hallway. That behavior was stopped immediately by a staff member. Res is now on another unit (Brickyard, an all male unit) for the day and will return after dinner to go to bed. "			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155636		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED	
		155636 	B. WING		01/15/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HARRISC	ON TERRACE			WELLESLEY BLVD NAPOLIS, IN 46219	
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
IAU	On 1/14/13 at 2 Executive direct documentation plans. He indict complete, accurately of all care Resident E.  Resident E's recare plan for on Existing care plan for on Existing care pinterventions restaffing.  Resident E's proposition of a documented above, began of A.M., when he and inappropriate resident agains 12/20/12 at 6:4 observed trying 12/	2:45 P.M. the ctor provided of Resident E's care ated this was a trate, and up to date e plans in place for ecord contained none on one staffing. It is a state to one on one one on one one on one one o	IAU		DATE
ı		a above.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SU COMPLET		
		155636	B. WIN			01/15/20	)13
	PROVIDER OR SUPPLIER		•	1924 W	DDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re (	(X5) COMPLETION DATE
	start dates, we "Problem: Behatimes resident	haviors, with problem re as follows: avioral Symptoms: At will eat other residents or drink." Problem start					
	"Problem: Beha	avioral Symptoms: xpose himself to others mpt to kiss and touch others."					
	Resident will ye sexually inapprothers especia attention seekiluse corrective	avioral Symptoms: cell, curse, and make copriate comments at lly during periods of ng and when others language such as ect. (sic) Problem start					
	intrusively wan other's rooms i items such as o	avior: Resident will der in and out of n order to remove clothing he will layer othing." Problem start					
	spit and make	avior: Resident will hit, sexually inappropriate ers especially during					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155636	B. WIN			01/15/	2013
NAME OF B	AN OLUMBER OR GURBLUE				ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
NAME OF P	PROVIDER OR SUPPLIEF	· ·		1924 W	ELLESLEY BLVD		
HARRISO	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	l '	ntion seeking and when					
		rective language such					
		no' ect. (sic) Problem					
	start date: 1/11	1/13.					
	A facility policy	titled "Care Plan					
		aintenance Process,"					
		the Director of Nursing					
		15/13 at 10:20 A.M.,					
		ntly revised on 8/11,					
	indicated:	Titly revised on or 11,					
	maicatea.						
	"Policv: It is th	e policy of this facility					
	that each resid						
		e care plan developed					
	based on com	-					
		The care plan will					
		rable goals and					
		ic interventions based					
	•	eds and preferences to					
		sidents (sic) highest					
		ning including medical,					
		al and psychosocial					
	. •	ii ana psychosocial					
	needs.						
	Procedure:C	are plan problems,					
		ventions will be					
	_	on changes in					
	•	sment/condition,					
		ences or family input."					
	. Soldoni proloi	one of fairing input.					
	An undated fac	cility policy, titled					
		cility's parent company)					
	•	agement Policy and					
		eceived from the					
	l					ļ	1

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Event ID: OJW911

Facility ID: 000241

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155636			LE CO	NSTRUCTION  00	(X3) DATE ( COMPL 01/15/	ETED
	PROVIDER OR SUPPLIE	R	19	24 WI	DDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		rsing Services on 20 A.M. and indicated facility policy,					
	parent comparinterventions a residents with distressing being provided are being non pharmacous supportive phyenvironment the preventing, relaccommodating distressed being procedure: Calinitiated for an affects, or has	ng a resident's navior.  The plans should be be a behavioral issues that the potential to affect,					
	should be take interventions a changed on th	other residents Care en to ensure that and behaviors are e care plan"					
	3.1-35(a)						

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Event ID: OJW911

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
		155636		01/15/2013			2013
			B. WIN		ADDRESS CITY STATE ZID CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
LIADDICC	ON TEDDACE				/ELLESLEY BLVD		
HARRISC	ON TERRACE			INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)					]	
SS=K	S=K FREE OF ACCIDENT						
	HAZARDS/SUPE	RVISION/DEVICES					
	•	ensure that the resident					
		ains as free of accident					
	•	ssible; and each resident					
	•	e supervision and					
		es to prevent accidents.	F02	22			02/00/2012
	Based on reco		F03	23	F 323 Resident E was placed one to one supervision	on	02/08/2013
	· ·	acility failed to provide			continuously and was relocate	d to	
		rvision to protect			reside on the all male unit on		
		behaviors of a newly			1/10/13. He continues to reside	е	
	admitted reside	ent (Resident E) that			on the all male unit and is on		
	were sexually i	nappropriate, and			continuous one to one		
	physically and	verbally aggressive,			supervision at all times as long	ງ as	
	and intrusive w	andering behaviors,			the resident remains in the		
		the newly admitted			facility. Residents who reside		
	•	physically and verbally			the facility have the potential to affected by the alleged deficien		
	•	ctions of residents to			practice. All other residents with		
					sexually inappropriate, physica		
		or 1 of 3 residents			and verbally aggressive, and	,	
		ehaviors in a sample of			intrusive wandering behaviors	,	
		nt practice potentially			care plans were reviewed to		
	affected 29 res	idents on the Mapleton			ensure residents had a		
	unit and 22 res	idents on the Chatham			comprehensive care plan to		
	Arch unit.				address the behaviors. An		
					inservice on Behavior		
	This deficient r	practice resulted in			Management including sexual	y	
		pardy. The Immediate			inappropriate behaviors was provided to staff by the Staff		
					Development Coordinator on		
		identified on 1/10/13			1/11-13/2013. Staff will call th	e	
	and began on				DNS when any physically		
		ctor and Director of			aggressive, verbally aggressiv	e or	
	Nursing Servic	es were notified of the			sexually inappropriate behavio		
	Immediate Jeopardy on 01/10/13 at				occur that is directed to another	er	
	4:45 P.M. The Immediate Jeopardy				resident. An immediate		
	was removed on 01/13/13, but the				intervention will be put into pla		
		ed out of compliance at			at that time. Nurses will condu		
	iacinty remaine	a out or compliance at			shift to shift report on any new		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155636	B. WIN			01/15/	2013
		1	b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			ELLESLEY BLVD		
HARRISO	ON TERRACE				APOLIS, IN 46219		
	- TERRITOR CE				Al OLIO, IIV 40219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	•		DATE
		tern, no actual harm			behavior management		
	with potential f	or more than minimal			interventions – relaying the interventions to licensed and		
	harm that is no	ot Immediate Jeopardy,			unlicensed staff. CNA assignm	nent	
	because the fa	icility still needs to			sheets are updated during IDT		
	ensure all resid	dents with behaviors			meeting. During weekends the		
	potentially affe	cting other residents			weekend supervisor will updat	е	
	have current a	•			CNA assignment sheets. The		
		health care and			IDT will review interventions to		
	· ·	have been reviewed			evaluate the effectiveness and		
		and appropriate			ensure there is no reoccurrence The behavior monitoring flow	æ.	
	•	and appropriate and supervision are in			sheet will be completed every		
		•			shift, and reviewed by the unit		
	place for all res	sidents.			managers to ensure care plan		
	l <u>_</u>				interventions were implemente		
	Findings includ	de:			New and worsening behaviors		
					be reviewed by the IDT on the		
	1. The record of	of Resident E was			next business day. Intervention		
	reviewed on 0°	1/10/13 at 3:00 p.m.			will be identified. The care plan and care sheets will be update		
					at that time. To ensure	u	
	Diagnoses incl	luded, but were not			compliance, the DNS/Designe	e is	
	limited to, Dow	n's syndrome.			responsible for the completion		
		tro esophageal reflux			the Behavior Management CC	)l	
		lipidemia, and celiac			tool weekly times 4 weeks,		
	disease.	iipiaaiiia, aira aaliaa			bi-monthly times 2 months and	d	
	4.00400.				then quarterly until continued compliance is maintained for 2	,	
	An admission	Minimum Data Set			consecutive quarters. The resi		
					of these audits will be reviewe		
	, , , , , , , , , , , , , , , , , , ,	ssment dated 12/18/12			by the CQI committee oversee		
		dent E was significantly			by the ED. If threshold of 95%		
		paired, was unable to			not achieved an action plan wi	II	
		terview to assess his			be developed to ensure		
	,	behaviors, ambulated			compliance.		
		e, and required staff					
	assistance for activities of daily living.						
	, ,						
	Documentation indicated Resident E						
	was admitted t	o the facility on					
		•					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155636	B. WIN	G		01/15/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KOVIDEK OK SOTTEIEF			1924 W	ELLESLEY BLVD		
HARRISO	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	12/11/12.						
	Progress Notes	s for Resident E					
	indicated:						
	12/20/12 5:46	A.M.: "The resident					
	was observed	kissing another female					
		) the mouth and it was					
	•	I. The resident was					
	also observed	inappropriately (sic)					
		esident. The resident					
	_	ely removed and told					
		as unacceptable. The					
		ne verbally aggressive					
		ake me stop you old					
	goat'"	and me stop you old					
	gout						
	12/20/12 6:45	P.M.: "Group of Xmas					
		roler's (sic) here on					
	, ,	nas carol's (sic). Res					
		npted to walk up to					
	,	puckered for a kiss.					
	•	nediately got between					
		sitor et removed res					
	, ,						
	_	tor. Other res started					
	• • •	I for "at") this res to sit					
	down and be q	uie(					
	40/00/40 0:07	D.M.: "Dog cont					
		P.M.: "Res cont					
	` ,	have behaviors this					
		ed up to a female res et					
	•	ic) self by holding his					
	-	nd et laughing (symbol					
	,	hen this writer					
	assisted res to	bed started (sic) trying					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155636	B. WIN	G		01/15/	2013
NAME OF P	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON BOTTELET	•			ELLESLEY BLVD		
HARRIS	ON TERRACE			INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to kiss this writ						
	immediately ex	cplained to res that he					
	should not kiss	anyone, or expose					
	himself to anyo	one. Res stated 'make					
	me. Res put or	n 15 min (minute) chk's					
	(checks) for be	haviors."					
	12/21/12 10:02						
	(Interdisciplina	ry Team) met to					
	discuss reside	nts (sic) new and or					
	worsening beh	avior that occurred on					
	12/19/12, 12/2	0/12, and 12/21/12.					
	Throughout the	ese days resident was					
	noted to have	been intrusively					
	wandering in a	nd out of other					
	residents (sic)	rooms, throwing his					
	meal beverage	es on the floor as well					
	_	ers (sic) foods,					
	` '	elf to other residents,					
		ally and physically					
	_	ard staff, attempting to					
		visitors that came on					
		kissing resident					
		ident) without her					
	,	interventions were					
		Resident continued to					
		ors until he was					
	assisted to be						
	assisted to bet	4					
	12/23/12 1:56	A.M.:"returned to this					
		early evening, Bx.					
	• •	gan almost immed.,					
	,	ambulated to other					
	· • • • • • • • • • • • • • • • • • • •						
		and entered, residents					
	began to yell						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED
		155636	B. WIN			01/15/	2013
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD		
HARRIS	ON TERRACE				APOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	ΓE	COMPLETION DATE
	into room (a ro Arch unit) and out to hallway, attempted to go res made contaside of face	back into rm (room) act with this res left Started 15 minute ety."  accord contained no of 15 minute checks. 10:30 A.M. the actor indicated he had ion of 15 minute berformed.  P.M.:"res has been dering into res rooms tinuously this shift, res as from peers and worn becomes agitated when o redirect him and as (sic) belongings,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
THIND TETHIN	or condition	155636		LDING		01/15/	
		.0000	B. WIN		ADDRESS CITY STATE ZID CODE	0 17 107	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD		
HARRISO	ON TERRACE				APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s. Staff redirects					
		s causes an increase					
	_	residents (sic) part. At					
		ident was walking in					
		station. A female					
		g in the other direction					
		t of res and reached					
		n on his arm. Res then					
		nd made contact with female resident. Staff					
	,	parated the two. The					
		een placed on constant on). Family has been					
	,	tempting to arrange					
		me in and sit with him					
	awhile to calm						
	awrille to call i	IIIII GOWII.					
	Resident E's re	ecord contained no					
	documentation						
		n 1/13/13 at 10:30					
	A.M. the Execu	itive Director indicated					
	he had no doci	umentation of constant					
	observation be	ing performed.					
	1/01/13 2:59 P	.M.: "res has been					
	wandering in a	nd out of res rooms					
	taking their bel	ongings, putting their					
		ing clothes out of					
		ng them all over the					
		nd taking things off the					
	linen cart stuffi	ng them in his pants"					
	1/02/13 2:17 P	.M.: "res acting very					
		uring breakfast res					
		g other residents,					
	<u> </u>	·					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Ì		NSTRUCTION 00	(X3) DATE S COMPL	
		155636	A. BUII B. WIN			01/15/	
	PROVIDER OR SUPPLIER		5. 112.	STREET A	ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	asking female in his fists up in the fight people, we other res room belongings and on. It is very diresident he yel redirected cause 1/03/13 2:32 A observed takin roommates (sic chesthe because aggressive using continues to put it to staff"  1/04/13 8:30 A attempted to king on the mouth dining room we for about 3 min (medications) if approached a fin behind and pull then began to residents (sic) we patting his gen his pants"	If putting others clothes Ifficult to redirect Is and screams when Ising a big scene"  I.M.: "Resident Ig clothes out of It drawers and Imme verbally Ing profanityalso Ill penis out and show  I.M.: "Resident Is a female resident Is a female resident Is a female resident Is a female resident It is a female resid		TAG			DATE

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	OF CORRECTION  OF CORRECTION  155636  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/15/2013
	PROVIDER OR SUPPLIER ON TERRACE	1924 W	ADDRESS, CITY, STATE, ZIP CODE ELLESLEY BLVD APOLIS, IN 46219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	(continues) with hoarding behaviors in spite of attempts to redirect. At breakfast, resident mocked another resident by repeating everything the other was saying to staff. When asked to quit, Res responded by saying 'Your momma is ugly' and flipping his middle fingers first at res then at staff. The two had to be separated when the other became angry and swung at res without making contact. In addition, res swung a belt at an aides (sic) head today. When cat in the hole was failing to get staff attention, res began yelling py and laughing."  1/07/13 11:05 A.M.: "Res noted by this writer to have another residents (sic) stereo headphones tucked down the front of his pants. Approached res and stated that I need to see those so they did not get broken. Res immediately began yelling 'No, they are mine' and took the headphones out and held them behind his back. When writer reached for headphones, res swung fist and attempted to make contact with staff members (sic) faceRes escorted from the female residents (sic) room where this occurred"  1/08/13 3:02 P.M.: "Res was wandering in and out of other res			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL	
AND TEAN	or connection	155636	A. BUIL			01/15/	
		1111	B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ELLESLEY BLVD		
HARRIS	ON TERRACE				APOLIS, IN 46219		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<b>+</b>	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	rooms this shi	•					
		ying to box with the staff ed, when asked to not					
		gs res states, 'who's					
		ne?' and res was also					
	~	o hump one of the					
		nts in the hallway. That					
		stopped immediately by					
		er. Res is now on					
		Brickyard, an all male					
		ay and will return after					
	dinner to go to	•					
		, bod.					
	A physician's	order dated 1/04/13 at					
		licated Resident E was					
	to receive Dep	oo Provera (a birth					
	control medica	ation prescribed for men					
	to reduce sexu	ually impulsive					
	behavior) 400	milligrams by injection					
	once a month.						
	During an inte						
		on 01/11/13 at 9:45					
		ited that the Mapleton					
		sidents with mild to					
		nentia, and that the					
		unit was for residents					
		anced dementia. He					
		the Chatham Arch unit					
		ropriate for residents					
		g behavior as the					
		e were less likely to be					
	aware of the behavior, and indicated						
	1	unit was a male only					
	unit for resider	nts with problematic					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  15/2013		
	PROVIDER OR SUPPLIEI	<b>.</b>	1924 W	ADDRESS, CITY, STATE, ZIP CO /ELLESLEY BLVD IAPOLIS, IN 46219	DE	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	on 01/11/13 at indicated, and provided, the Fresident on the 12/11/12 throuresided on the from 12/31/12 During an inter 2:00 P.M. the I Manager indicated that Resident I the Chatham A was noted that hours on the B 12/21/12, 12/2 12/24/12. He of the Chatham A time. He was the Brickyard unit 01/10/13 when leave of absendant of the I was a series of a series of a series of I will be a series of I	and Director of Nursing 10:45 A.M., it was documentation was Resident E had been a Mapleton unit from gh 12/31/12, and Chatham Arch unit through 01/10/13. view on 01/14/13 at Business Office ated this was incorrect, had actually moved to arch unit on 12/28/12. It he spent daytime rickyard unit on 2/12, 12/23/12, and continued to reside on arch unit through this ransferred to the on the evening of he returned from a ce with family.  cility document titled cility's parent company) agement Policy and ceived from the rsing Services on 20 A.M., and indicated						

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION  . DUM DIVIS			(X3) DATE SURVEY  COMPLETED			
THIE TEAT	or condition	155636		LDING		01/15/			
			B. WIN		ADDRESS CITY STATE ZID CODE	0 17 101			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE  1924 WELLESLEY BLVD					
HARRISON TERRACE			INDIANAPOLIS, IN 46219						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION		
TAG				IAG	DEFICIENCY)		DATE		
	,	e policy of (name of y) to provide behavior							
		• / •							
	interventions and monitoring for residents with problematic or								
	distressing behaviors. Interventions provided are both individualized and								
	· .	ogical and part of a							
	•	sical and psychosocial							
		at is directed toward							
	preventing, reli	eving and/or							
	accommodating	g a resident's							
	distressed beh	avior."							
	An Immediate								
		10/13 at 4:00 p.m. The							
		pardy began on							
		Resident E was							
		ng and inappropriately							
	_	ale resident against I later exposed himself							
		ident. The Executive							
		rector of Nursing							
		notified on 1/10/13 at							
		e Immediate Jeopardy							
		of supervision to							
		y and physically and							
	sexually inappr	opriate behaviors. The							
	Immediate Jeo	pardy was removed on							
		through observations,							
		record reviews, it was							
	determined the	•							
		ne plan of action to							
	remove the imr								
	problem. The r								
	transferred to a	n all male secured							

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	of correction (155636)  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155636	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/15/2013			
	PROVIDER OR SUPPLIER ON TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION			
	unit, was placed on continuous one on one staffing, and staff were updated on new behavior management strategies. The Unit Manager and one on one attending staff were interviewed and adequately expressed understanding of the situation. They noted the resident had no notable behaviors since starting one on one staffing. The resident was observed multiple times over a 3 day period and no behaviors were observed. The facility instituted a log for caregivers to enter notes every 15 minutes and this was being followed. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at the level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.  This federal tag relates to complaint IN00121723.  3.1-45(a)(2)						

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